House of Representatives

General Assembly

File No. 114

January Session, 2005

Substitute House Bill No. 6790

House of Representatives, March 30, 2005

The Committee on Program Review and Investigations reported through REP. SHARKEY of the 88th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE RELATIVE TO THE MEDICAID ELIGIBILITY DETERMINATION PROCESS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-277 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women and children up to one year of age whose families have an income up to one hundred eighty-five per cent of the federal poverty level.

(b) The commissioner shall **[**implement presumptive**]** <u>expedite</u> eligibility for appropriate <u>pregnant women</u> applicants for the Medicaid program<u>.</u> **[**with an emphasis on pregnant women. Such presumptive

eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall provide such presumptive eligibility determinations on a pilot basis, in one district office, beginning June 1, 1991, and shall provide them state-wide effective September 1, 1991.**]** The process for making expedited eligibility determinations concerning needy pregnant women shall ensure that emergency applications for assistance, as determined by the commissioner, shall be processed no later than twenty-four hours after receipt of all required information from the applicant, and that nonemergency applications for assistance, as determined by the commissioner, shall be processed no later than five calendar days after the date of receipt of all required information from the applicant.

(c) The commissioner shall submit biannual reports to the council, established pursuant to section 17b-28, on the department's compliance with the administrative processing requirements set forth in subsection (b) of this section.

Sec. 2. Section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed three hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B. The services and cost-sharing requirements under the HUSKY Plan, Part B shall be substantially similar to the services and cost-sharing requirements of the largest commercially available health plan offered by a managed care organization, as defined in section 38a-478, offered to residents in this state as measured by the number of covered lives reported to the Insurance Department in the most recent audited annual report.

(b) A child who resides in a household with a family income over three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.

(e) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his date of birth, provided an application is filed on behalf of the child within thirty days of such date.

(f) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application for Medicaid is submitted to the department for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

[(f)**]** (g) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The servicer shall jointly market both Part A and Part B together as the HUSKY Plan. Such servicer shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part B to the commissioner.

(h) Upon the expiration of any contractual provisions entered into pursuant to subsection (g) of this section, the commissioner shall develop a new contract for single point of entry services and Medicaid managed care enrollment brokerage services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time limits for the processing of applications, parameters setting forth the requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

[(g)**]** (i) The single point of entry servicer shall send an application and supporting documents to the commissioner for determination of eligibility of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level. The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan. Upon enrollment in a managed care plan, the eligible beneficiary shall remain enrolled in such managed care plan for six months from the date of such enrollment unless the eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan.

[(h)**]** (j) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to make a determination on eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A and Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the

participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The determination of eligibility shall be coordinated with health plan open enrollment periods.

(k) The commissioner shall develop a system to allow applicants for health insurance coverage under HUSKY Plan, Part A and Part B to complete such applications on-line through use of the Internet. Such system shall provide for: (1) The automated transmittal of application data to the department's computerized eligibility management system, (2) the acceptance of electronic signatures, (3) a mechanism that ensures that only completed applications may be electronically forwarded to the department, and (4) security measures that ensure that information provided in such on-line applications remain subject to the protections of section 17b-90 and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Such system shall be available on a pilot basis not later than March 1, 2006, and shall be available state-wide not later than July 1, 2006. The commissioner shall collaborate with qualified entities, managed care plans and providers to promote the use of such an on-line system.

[(i)**]** (l) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(j)**]** (m) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 3. Section 17b-261 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (d) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence, pending federal approval, except that the medical assistance program shall provide coverage to persons under the age of nineteen up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Said medical assistance program shall also provide coverage to persons under the age of nineteen and their parents and needy caretaker relatives who qualify for coverage under Section 1931 of the Social Security Act with family income up to one hundred per cent of the federal poverty level without an asset limit, upon the request of such a person or upon a redetermination of eligibility. Such levels shall be based on the regional differences in

such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. All contracts entered into on and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care organizations with the Healthy Families Connecticut Program established pursuant to section 17a-56. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance.

(b) For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

(c) For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to special needs trust, as defined in 42 USC 1396p(d)(4)(A).

(d) The transfer of an asset in exchange for other valuable consideration shall be allowable to the extent the value of the other

valuable consideration is equal to or greater than the value of the asset transferred.

(e) The Commissioner of Social Services shall seek a waiver from federal law to permit federal financial participation for Medicaid expenditures for families with incomes of one hundred forty-three per cent of the temporary family assistance program payment standard.

(f) Notwithstanding the provisions of subsection (a) of this section, on or after April 1, 2003, all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level, who are receiving medical assistance pursuant to this section, shall be ineligible for such medical assistance. On and after February 28, 2003, the Department of Social Services shall not accept applications for medical assistance program coverage under Section 1931 of the Social Security Act from parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level until on or after July 1, 2005.

(g) To the extent permitted by federal law, Medicaid eligibility shall be extended for two years to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act while one of its members who is a caretaker relative is employed or due to receipt of child support income or a family with an adult who, within six months of becoming ineligible under Section 1931 of the Social Security Act becomes employed.

(h) An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse in order to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in Section 1924 of the Social Security Act. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in Section 1924 of the Social Security Act. The Commissioner of Social Services, pursuant to section 17b-10, may implement the provisions of this subsection while

in the process of adopting regulations, provided the commissioner prints notice of intent to adopt the regulations in the Connecticut Law Journal within twenty days of adopting such policy. Such policy shall be valid until the time final regulations are effective.

(i) The Commissioner of Social Services shall pursue a waiver from federal law to the Centers for Medicare and Medicaid Services to permit the standard of promptness for processing Medicaid long-term care applications to be extended from forty-five days to ninety days and to provide that the redetermination period for Medicaid long-term care applications be extended from one year to two years.

Sec. 4. (*Effective July 1, 2005*) The Commissioner of Social Services, in consultation with the department's regional administrators, shall monitor the processing of Medicaid applications by the district offices of the department to determine whether there are variations between such offices concerning overdue applications, denial of applications and redeterminations for program eligibility, and if such variations are found to exist, the reasons therefor. Not later than January 1, 2006, the commissioner shall report, in accordance with section 11-4a of the general statutes, findings on the causes of variation in the processing of Medicaid applications by the district offices of the department, including any quantitative or qualitative factors that contribute to such variation, to the joint standing committee of the General Assembly having cognizance of matters relating to human services.

Sec. 5. (*Effective July 1, 2005*) The sum of one million dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2006, for personal services to permit the department to hire an additional fourteen eligibility determination employees to facilitate the expeditious processing of applications for programs administered or operated by the department.

This act shall take effect as follows and shall amend the following sections:

Section 1	*July 1, 2005*	17b-277
Sec. 2	*July 1, 2005*	17b-292
Sec. 3	*July 1, 2005*	17b-261
Sec. 4	*July 1, 2005*	New section
Sec. 5	*July 1, 2005*	New section

PRI *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 06 $	FY 07 $
Department of Social Services.	GF - Cost	Significant	Significant

Municipal Impact: None

Explanation

This bill makes various changes to the Medicaid eligibility process.

Section 1 of the bill replaces the current presumptive eligibility process for pregnant women with "expedited" eligibility. This new process, by allowing both quicker provision of services and a simpler eligibility process for pregnant women will likely increase the number of clients enrolled in the Medicaid Managed Care program. This will lead to increased Medicaid costs. The state currently pays $2,280 annually for each individual enrolled in the Medicaid Managed Care program. This section also requires the Department of Social Services (DSS) to submit a new biannual report. This requirement will lead to minimal increased administrative costs to the department.

Section 2 of the bill restores the presumptive eligibility process for children applying for Medicaid. Based on past departmental experience, resumption of this policy is expected to increase Medicaid enrollment at a cost of approximately $3.5 million annually.

Section 2 also requires DSS to develop a new contract for the single point of entry servicer. Development, negotiation and execution of this contract will lead to increased staff costs to the department. DSS pays the current servicer approximately $540,000 annually in

administrative costs. Depending on the details of the new contract that is to be developed, this cost could also change. The scope and direction of these changes cannot be determined prior to the development of the new contract.

Section 2 further limits the frequency of which HUSKY enrollees may switch managed care plans to once every six months. This change will lead to savings to the Medicaid Managed Care Organizations through a reduction of program administration complications. To the extent that these savings are passed on to DSS through future Medicaid managed care rate negotiation, a savings to the state may result.

Finally, section 2 requires DSS to develop an on-line application system for HUSKY A and HUSKY B. A pilot program is to be available by March 1, 2006, with a state-wide system available by July 1, 2006. This requirement will result in a significant increased cost for the department. The extent of this cost will be dependent upon the system design and program execution. On-line application systems in other states have had costs that range from $40,000 in Georgia to over $1 million in California. It should be noted that section 26 of P.A. 04-216 (the Budget Act) made $200,000 available in FY05 for a statewide on-line Medicaid and HUSKY enrolment system.

Section 3 requires DSS to seek a federal waiver increasing the amount of time it has to grant long-term care eligibility as well as extending the duration of this eligibility. These changes are not expected to change the outcomes of the eligibility determination process, and therefore will not change long-term care programmatic costs. Rather, the changes will help reduce application and redetermination backlogs.

Section 4 requires the DSS commissioner to monitor the processing of Medicaid applications in regional offices and submit a report on her findings to the General Assembly by January 1, 2006. This requirement will lead to minimal increased costs to the department.

Section 5 appropriates $1 million to DSS in order to hire an additional 14 eligibility determination employees.

OLR Bill Analysis
sHB 6790

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE RELATIVE TO THE MEDICAID ELIGIBILITY DETERMINATION PROCESS

SUMMARY:
This bill makes numerous changes in the way the Department of Social Services (DSS) processes applications for Medicaid, including HUSKY A and HUSKY B.

It (1) restores presumptive eligibility for children applying for HUSKY A and codifies "expedited" Medicaid eligibility for pregnant women; (2) requires DSS to develop a new contract for its single point of entry "servicer," which is required by law to provide enrollment assistance and outreach to HUSKY A and B applicants, and requires any future contracts to include performance measures; (3) appears to allow HUSKY enrollees to switch managed care organizations (MCO) every six months; and (4) requires DSS to develop a system of on-line HUSKY applications.

The bill also requires DSS to request a federal waiver to enable it to (1) increase the amount of time it has to grant eligibility to people applying for Medicaid long-term care eligibility and (2) extend eligibility duration for these individuals.

The bill requires DSS to monitor Medicaid application processing in the regional offices to determine whether variations in overdue rates and application disposition exist and the reasons why. She must report on the reasons to the Human Services Committee by January 1, 2006.

The bill appropriates $1 million to DSS' personal services account in FY 2006 to enable the department to hire 14 additional eligibility determination employees to expedite application processing.

Finally, the bill repeals obsolete language.

EFFECTIVE DATE: July 1, 2005

MEDICAID AND HUSKY B

Restoring Presumptive Eligibility (PE) for HUSKY A Children

The bill requires the DSS commissioner to reinstitute PE for children applying for HUSKY A coverage. PE determinations must be made in accordance with applicable federal law. (In essence, PE enables children to start getting HUSKY A coverage while DSS is in the process of completing the eligibility determination.)

It requires DSS to adopt regulations to establish standards and procedures for designating organizations as "qualified entities" to grant PE. These entities must ensure that at the time they grant PE, a completed Medicaid application is submitted to DSS for a full eligibility determination. In adopting the standards and procedures, DSS must ensure representation of statewide and local organizations that provide services to children.

PA 03-3, June 30 Special Session, eliminated PE for HUSKY A children. Until then, DSS used qualified entities to make PE determinations, using the same requirements as those required in the bill.

Expedited Eligibility for Pregnant Women

The bill requires DSS to expedite Medicaid eligibility for pregnant women. DSS must ensure that it processes (1) emergency applications, as the commissioner determines, within 24 hours from when it receives all required information from the applicant and (2) all other applications no later than five calendar days after receiving the information.

The bill requires the commissioner to submit reports every two years to the Medicaid Managed Care Council on how it is complying with these deadlines.

Under current law, DSS must perform PE for these women, which must be in accordance with federal law. In practice, DSS has never implemented PE per se, as authorized by federal law. Instead, it implemented expedited eligibility for these women using standards different from the federal PE ones. State regulations require DSS to

grant PE within one day from when it receives required minimum information (e.g., proof of identity and citizenship status and income), and requires that the applicants get the required information to DSS within 30 days of applying.

Contractor for Medicaid Managed Care (HUSKY A) and HUSKY B Services

By law, DSS must contract with an entity to be a single point of entry "servicer" for HUSKY A and B applicants and enrollees. In addition to providing enrollment assistance, the servicer must do outreach and provide public information about these programs. DSS currently contracts with ACS, Inc.

The bill requires DSS, when its existing contract expires, to develop one or more new contracts for single point of entry services and Medicaid managed care enrollment brokering. It also allows her to enter into more than one contract, the duration of which cannot exceed seven years. The ACS contract, in place since 1995, expired in December 2004. It has never been formally re-bid.

Any future contract must include performance measures, including (1) time limits for processing applications, (2) parameters establishing requirements for completed and "reviewable" applications, and (3) the percentage of applications forwarded to DSS in a complete and timely fashion. The contracts must also include a process for identifying and correcting noncompliance with performance measures, including sanctions when continued noncompliance occurs.

Enrollees' Ability to Change MCOs

The bill requires "eligible beneficiaries" to remain enrolled in a managed care plan for six months before they can switch to another plan, unless they can demonstrate good cause for switching sooner. It is not clear whether "eligible beneficiaries" refers to HUSKY Part A, HUSKY Part B or both. Under current DSS regulations HUSKY B enrollees may only switch plans once a year. HUSKY A enrollees can switch more often.

On-Line Applications

The bill requires the DSS commissioner to develop a system to allow HUSKY A and B applicants to apply for coverage on-line via the

Internet. The system must provide for (1) automated application transmittals to DSS' existing eligibility management system; (2) acceptance of electronic signatures; (3) assurances that only completed applications get electronically "forwarded" to DSS; and (4) security measures that insure the information transmitted remains confidential, as required by the federal Health Insurance Portability and Accountability Act of 1996. DSS must collaborate with the qualified entities, MCOs, and providers to promote the system.

This system must begin as a pilot program no later than March 1, 2006, and become statewide by July 1, 2006.

Waiver to Extend Standard of Promptness and Redetermination Period for Long Term Care Applications

The bill requires the DSS commissioner to request a federal waiver to extend the amount of time it has to process Medicaid applications (called the "standard of promptness") for individuals applying for long-term Medicaid care (e.g., nursing home care) from 45 to 90 days. The waiver must also include a request to process Medicaid re-determinations of eligibility every two years instead of annually. (HUSKY A enrollees can switch plans as frequently as they wish.)

Monitoring DSS Regional Office Variations

The bill requires the DSS commissioner, in consultation with her regional administrators, to monitor Medicaid application processing in the district offices to determine whether and why variations exist with respect to (1) overdue applications and (2) application and re-determination denials.

She must report to the Human Services Committee by January 1, 2006 on the causes of these variations, including quantitative or qualitative factors.

BACKGROUND

HUSKY A AND B

HUSKY A is Medicaid coverage for children in families with incomes up to 185% of the federal poverty level (FPL)(currently $29,766 annually for a family of three) and certain caretaker relatives with lower incomes. HUSKY B provides health care coverage (65% federal

match for state expenditures) to children in families with higher incomes. HUSKY B is subsidized for children in families with incomes under 300% of FPL ($48,270 for the same family). There is no cost sharing in HUSKY A; HUSKY B requires co-payments and premiums for families with incomes between 235% and 300% of the FP.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute
Yea 10 Nay 0